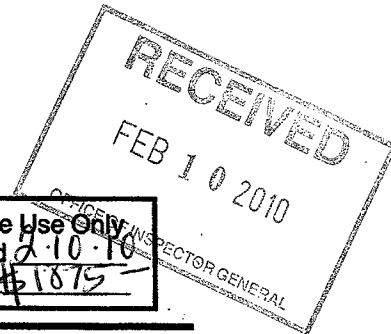


mailed validation
letter 2/26/10



**Application for License to
Operate a Long-term Care Facility**

For Office Use Only
Received 2-10-10
Amount \$1875

I. IDENTIFICATION

ck# 10777

Name Williamsburg Nursing Home
Address Po Box 719
City/County/Zip Williamsburg, Whitley, 40769
Telephone number 606 549-4321
Administrator Michelle Jarboe
Date facility operation began at current address 3-27-78
Date facility began operation under current owner 3-27-78

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	<u>25</u>	
Nursing Home		
Nursing Facility	<u>125</u>	
Intermediate Care		
ICF/MR		
Personal Care		

II. CONTROL (check one in each column)

State
County
City
Private

Profit
Nonprofit

Individual
Partnership
Corporation

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

Williamsburg Nursing Home, Inc
Po Box 1450
Corbin Ky 40702

(OVER)

2/28

If facility owned or leased by a corporation, complete the following:

Name of corporation Williamsburg Nursing Home, Inc
Address of corporation P.O. Box 719, Williamsburg, Ky 40709
President or Chairman Terry E. Forcht
Vice President Rodney Shockley
Secretary Jackie Willis
Treasurer _____

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company
<u>FIRST Corbin Long-Term Care</u>	_____
<u>PO Box 1450</u>	_____
<u>Corbin Ky 40702</u>	_____

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Michelle Garboe
Signature of authorized representative

Administrator 1/28/10
Title Date

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)